Regional EMS Council Process Action Team Meeting
Embassy Suites
Hampton, Virginia
April 29, 2008
8:30 a.m.

Members Present:	Members Absent:	OEMS Staff:	Others:
Gary P. Critzer, EMS Council Board President, PAT Chair	**Jerry Overton**, Urban Based EMS Service Representative	Scott Winston	Kent Weber, TEMS/Virginia Beach EMS
Dr. Rob Logan, EMS Council Executive Director	**Bruce Edwards**, EMS Advisory Board Member	Wanda Street	Bill Downs, TJEMS
Tina Skinner, EMS Council Executive Director		Mike Berg	Jeff Meyer, PEMS
Dr. Scott Weir, Operational Medical Director		Dennis Molnar	Connie Purvis, BREMS
Dr. Jack Potter, Designated Trauma Center Representative		Michael D. Berg	Melinda Duncan, NVEMS
Dr. Theresa Guins, Physician Member of EMS Advisory Board			David Cullen, CSEMS
Donna Burns, EMS Council Board President			Heidi Hooker, ODEMSA
Dreama Chandler, VAVRS President			Bob Ryalls, James City Co. Fire/EMS
Randy Abernathy, VAGEMSA President			Tracey McLaurin, LFEMS
Chris Eudailey, President, Virginia Fire Chief's Association			Gregory Woods, SVEMS
Scott Hudson, Rural Based EMS Service Representative			Tracy Thomas, ODEMSA
Jason Campbell, Virginia Professional Fire Fighter/VML Representative			Jim Chandler, TEMS
Gary R. Brown, OEMS Director			Jo Richmond, PEMS
Dr. Lisa Kaplowitz, Virginia Department of Health (ex-officio member)			Kim Johnson, James City Co. Fire/EMS
Tim Perkins, OEMS Staff to PAT			James Gray, Hampton
			Carlton Burkhammer, Fairfax Co. Fire/Rescue
			Ray Whatley, NVEMSC/Alexandria Fire Dept.
			Brian Hrick, NVEMSC/Alexandria

Members Present:	Members Absent:	OEMS Staff:	Others:
			Fire Dept.
			Byron Andrews, NVEMSC/Sterling Rescue
			Belinda A. Pasker, VDH, PHD, MRC, EP&R

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
Call to Order:	The meeting was called to order by the chair, Mr. Gary Critzer, at 8:38 a.m. Gary Critzer apologized for leaving the written agenda at his office in Waynesboro.	
Review & Approval of the Minutes dated March 20, 2008:	A motion was made and seconded to approve the minutes.	**The minutes were approved as submitted.**
Responses to questions posed at the February 25 meeting- Tim Perkins:	Tim handed out an updated spreadsheet of the Non-Contract items reported by the Regional Councils. Gary Critzer and the council directors had a few changes. This spreadsheet is based on the information that the eleven regional councils gave at the last PAT meeting in Charlottesville. It will be updated again and distributed at the next meeting. Questions related to the charge of the PAT had been asked of OEMS staffers at past meetings. Tim Perkins provided information related to those questions: What types of reviews have been conducted by other states concerning their regional EMS Systems? Information related to the results of the NASEMSO (National Association of State EMS Officials) survey that was conducted in August was forwarded to the PAT Chair, and then passed on to the PAT members. The language related to Regional EMS Council designation included in the budget amendment, as well as Dr. Remley's variance of the regulations were presented and discussed Question 3 – Randy Abernathy asked, what have other states done in response to the IOM report? The OEMS position paper statement that was given to the GAB in 2006 to Gary Critzer. OEMS informed the PAT chair that NASEMSO would be the responsible party for spearheading surveys such as those, as we have discussed. A. Economy of scales (accounting, human resources, IT, supply and equipment purchases, executive leadership, etc.) As has been discussed, there is no way to accurately measure this. OEMS cannot put a finger on any variation in costs from one Council to another related to IT costs. It can be deduced that there will be cost savings by reducing the costs related to HR, such as insurance, and that some Councils have taken on that task themselves.	

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	Executive leadership is separate issue. There have been a lot of changes in executive leadership. It has lead and is still leading to some significant problems for the remaining council staff members, other councils and for the OEMS. B. Ability to evaluate the cost effectiveness of the current arrangement and structure. We must be able to demonstrate fiscal responsibility. This addresses Dr. Kaplowitz comments. As mentioned before, the cutting down of duplicative services, while making mention of how the designation process, as well as site visits would play a major role in determining the applicant's ability to be fiscally responsible. Some Councils will be demonstrating how very little they depend on OEMS financially, while others simply cannot. This is one of the items that can be leveled with the proposed processes. C. Improved regional planning and coordination. (Focus on relationship between regional EMS Councils and Regional Hospital Coordination Centers). Do these relationships exist? OEMS has had evidence of limited participation in the development processes of plans required through the contract, especially among board members and other constituents. Despite the distribution of templates by OEMS, there remains evidence of plans that were completed in a less than standard fashion in terms of quality; that the Council staffs, as well as their boards, need to take ownership of. D. Lack of consistent TPI and PI processes. OEMS is considering working with the designated Trauma Center to complete this task. This is a contract deliverable for the current quarter, so OEMS does not have the most current plans from the Regional Councils. However, feedback that the Regional Councils received from last year's PI/TPI plans were discussed, making mention of variations and deficiencies. E. Lack of consistency in registration and administration of Consolidated Test Sites. OEMS staff has received lots of feedback from the OEMS Program Representatives concerning this. . Much of the comments seem to be centered on the variation in service across the regional boundaries. F. No consistency in how Board of Directors are formed and their charge. As was discussed at previous meetings, OEMS does not know the exact makeup of Council Boards, versus "executive committees" and the like. Not to mention variations in the way that minutes are taken and reported. Accuracy among some is questionable.	

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	G. No consistency in how RSAF grants are evaluated, graded, and prioritized. This is a difficult topic, given the regulations governing this process. However, OEMS has had situations where Regional Council projects were of a questionable efficacy or impact in the region. H. No consistency in how ALS Coordinators are endorsed. Narrative information from the Division of Educational Development was gathered, outlining variation and inconsistencies that exists in processes across regional boundaries. I. Variation in regional medical treatment protocols and medication exchange programs. Many of the stakeholders in the state have been literally screaming for standard protocols and medications for a very long time. The reduction in variation of other services not only lends to this process, but can be a roadmap to doing such a thing. J. Demonstrate how financial support from local government and other organizations varies widely. Dennis Molnar provided information regarding the distribution of Return-to-Locality (RTL) funds across the regions. K. The current financial condition at ODEMSA should be clearly identified and reported to the PAT. This information was provided to the PAT by ODEMSA staff at the March meeting in Charlottesville. There have been situations where the lack of succession plans are a portion of problems that exist among the councils after turnover…often these new directors are thrown to the deep end of the pool. L. History of compliance with reporting deadlines for all deliverables by the regional EMS councils. Feedback was distributed to the council directors related to second quarter deliverables. PAT members were asked to open their binders to the Central Shenandoah Contract, page 5 of 23. The work that is related to that part of the contract is pretty basic and specific. It is only a couple of paragraphs. M. Statement about the quality of the work products. Is this an example of best practices? Maybe on paper, but in reality, how are things conducted? Last year OEMS received a plan from a Regional Council that had "cut and pasted" another councils' plan and left the directors' name on the plans. As mentioned before, OEMS has had evidence of limited participation in the development process of plans required through the contract, especially among board members and other constituents. Despite the distribution of templates by OEMS, there remains evidence of plans that were completed in a less than standard fashion in terms of quality, which they, as	

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	well as their boards, need to take ownership of. OEMS has encouraged sharing, but not plagiarization plans, and to be sure to obtain stakeholder involvement. N. Variation in menu of services. Basic services are dictated by OEMS. These requirements come from the objectives for a comprehensive, efficient and effective emergency medical care system and are outlined in the Code of Virginia. The councils did an excellent job at the last meeting in presenting the things they do outside of the contract. One question that comes to mind is: do the basics that OEMS asks for in the contract get sacrificed because of the other things that they do? O. OEMS is attempting to achieve greater uniformity and standardization. The regions want local control and flexibility. No individual Regional EMS Council needs are more important than the needs of the EMS system. OEMS is mindful of each councils' identity and connection to the communities they serve. P. OEMS is attempting to achieve operational uniformity. The method and manner used to achieve the objective (outlined in the Code of Virginia) is left up to the Regional EMS Council. OEMS strives to balance the Region's need for local autonomy with the systems approach for providing emergency medical services. OEMS does not want to stifle autonomy because it leads to innovation and quality improvement. OEMS would like to maintain a good working relationship with all eleven council directors. Regardless of what the outcome of all this is, there is still work to be done. Donna Burns asked, by changing the regional councils from 11 to 7 or whatever the number may be, how do you see the issues that you brought up change? How would those issues change? Tim stated that a lot of change will occur by looking at the past and making things more efficient.	

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Review and Discussion of the current regional council contract:	Randy Abernathy wants to know the role of the board of directors. Someone made a comment to me several years ago saying, "I report to my board of directors". That leads me to believe that there might be an underlying assumption or mindset of answering to their board and to whom do they answer to? I'm concerned about where the board of directors fit in, what their liability issues are for failure to comply with the contract and what is OEMS prepared to do to ensure that there is compliance to the contract. Do we need to make the contract to the board instead of the regional council directors? Gary Critzer stated that he signs the contract after the executive committee reviews it. Our executive committee and Board oversees the operations, but the Executive Director runs the day to day operations. But I sign and date the contract. So the Office of EMS is contracting with the corporate structure of the Central Shenandoah EMS Council, not with Dave Cullen. Randy asked if incorrect information is sent to the EMS office, who is responsible for that, you or the board of directors? Gary Critzer said ultimately the board is responsible. Tim said that there are people sitting at the table who have not seen their Regional EMS plans. We have seen through reviews of plans and quarterly reporting of Board minutes that the board members and/or directors aren't reviewing/approving those submissions. Dr. Jack Potter stated that it boils down to accountability. How does accountability change whether you have 6, 9 or 12 regional councils? How do you monitor and establish an accountability team? Also in defining how many regions there are, the differences and similarities in the characteristics of each region should define the districts. Administrative accountability should be worked on separately and is a very important characteristic based on what was just said. Tim replied that he is trying to explain some of the issues that exist and accountability is one of them. Gary Critzer stated that he believes that there are line items in the contract that says if deliverables aren't met, then payments are withheld, etc. Are the councils being held to that statement? Tim says the Office has given some leeway in that area. We are looking at ways to address some of the issues in getting the councils to provide information to us in a timely manner. We report our feedback of deliverables to the executive directors. With the expectations that whatever feedback is given, based on contract deliverables, positive or negative, he relays it back to you. Gary Critzer does not feel that he should have to manage the council. If there are deficiencies, I would like to know about them.	

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	Gary Brown asked for a show of hands of PAT members who serve on regional council boards. He then asked to see how many of them have seen the report card that Tim sends to the regional councils. About half of them have seen the report cards. Tim stated that in the past there was a suggestion about adding the board presidents to a listserv to include the Board Presidents email addresses to keep them informed but we were met with some significant resistance. From a board president perspective, per Gary Critzer, that needs to be revisited ASAP. Maybe there is an opportunity for a Board President Forum or meeting where we meet occasionally to talk about certain issues. He doesn't think they need to be in the loop about everything, just the important issues. The first thing I would do is call a special executive board meeting to discuss what the issue is and why are we being held accountable or our payment is delayed because we did not meet the deliverables. On the other hand, if we have issues with accountability, and I know the Office of EMS tries hard not to play hard ball, but maybe it's time that you do. Maybe you should hold people accountable and withhold that $20,000, $30,000 or $40,000 payment. It might wake up some people. Tim stated that the problem with that is some regions will have to shut their doors. They rely on the funding from OEMS. I've talked with Dennis about this many times and we are limited to what we can do. Per Randy Abernathy, if we look at the alignment of say the Department of Fire Programs or State Police, everyone has differences on how they provide for the needs of the citizens; it seems to go against the descriptions or job responsibilities as board members for the advisory board and the council directors contract when it says a coordinated delivery of services of emergency medical services. If everybody is operating on a different map, that's not a coordinated delivery of services as it relates to the broader scope of public safety issues. If we are going to have a coordinated system, we need to broaden our thought processes. Dr. Jack Potter agrees that administrative oversight is a key factor in the success of any system. And stated that he thought the essence of what this committee was going to discuss is the best organizational structure to deliver the EMS services in the state of Virginia. Is it our current system or should it be different? Gary Critzer said that is the intent of this group. At the first 3 meetings of the PAT, we tried to get everyone on the same page about what's going on with the regional council service delivery, what exist today and what are the issues with the regional councils. The next thing we talked about was the contract. Are the deliverables in the contract really what the system in Virginia needs? Are there things that need to be taken out or added to the contract? I think we need to understand what we are going to deliver, before we decide how we are going to deliver it. Does that not make sense? I know that some of you want to get to the meat of this. You are worried about the maps.	**Revisit adding the board president email addresses to the listserv.**

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	Tim stated that he believes in the scope of the services in the contract. I know that every council director may not agree to every word in the contract. The other thing is that we have provided opportunities for the directors to implement programs in their regions to have impact. I think that if the PAT really wants to get into the deliverables of the contract, you are going to get away from what the charge of the council was initially and you're going to want to take things out of the contract. I'm not sure if talking about what specifically is in the council contract is something that this committee should be discussing. Gary Critzer stated that respectfully he would have to disagree with Tim. He thinks that what we deliver is as important as how we deliver it. I realize that we can't have an all inclusive contract. Dr. Guins asked if there was any other committee that has the charge of deciding what is in the contract. Gary Critzer stated that he did not know of any. Scott Hudson stated that he believes that going through the contract will take a lot of the committees' time and also the regional council's time and we will never get to the root of what we are here for. I think we need to concentrate on the services per council as we have been leading in that direction and ultimately taking the services and spreading them out throughout the regional councils and making that a statewide effort as far as what's delivered. Gary Critzer wanted to know if the group was satisfied with the contract and should move on to the next item of discussion. What we may do is appoint some of the regional council directors and a couple of regional council presidents along with the staff to discuss the contract. Gary Critzer asked Dave Cullen to work with the regional directors to update the spreadsheet and send an updated copy to he and Tim and it will be redistributed to the group at the next meeting. The next big challenge is to talk about the regional council designated service areas.	**Dave Cullen will work with the regional directors to update the spreadsheet and forward a copy to Tim and Gary C.**
Review and Discussion of regional council service areas:	Turn your binders to the section that says Regional Council Designation Maps. I believe our charge is to go to Map C. Tim explained how Map C came to be. Map C was one of the few alternate proposed service area maps and after receiving a lot of feedback, was acceptable to us. Map C mirrors Map 15- DMAS Non-Emergency Transport Region map. Gary Critzer wanted to know, "What is the benefit of these service areas over the current service areas?" Chris Eudaily asked if it would be beneficial to have a presentation done by ASMI, the company that did completed the *"Study of Regional EMS Councils in Virginia, 2007"* in order to have them explain	

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	how they arrived at these recommendations. I would like to get the committee's thoughts on this. Gary Critzer stated he had spoke with Gary Brown and Scott Winston concerning this and they thought it would be good to have Kevin McGinnis speak with the committee. However, he could not be with us today. There is a possibility of a teleconference or webinar which could be done from our own offices. Tim stated that a webinar or teleconference could be set up by the next PAT meeting. Gary Critzer asked if the group feels that speaking with Mr. McGinnis would be important. Rob Logan stated that he is not convinced that the consultant had all of the objectives that we have. **A motion was made by Dr. Jack Potter that this committee create a list of what the driving factors that we should use in setting up the boundaries. Motion was seconded by Tina Skinner.** **Dr. Jack Potter redefined his motion and stated that the committee should start from scratch, not using any of the maps.** A PAT member asked "Are you saying that the report that was done has no validity at all?" Tina Skinner stated that she doesn't think that. But she feels that the maps that are provided in the book are good reference and resource points. Jason Campbell wants to be given an example of one of the factors that are going to be used in setting up the boundaries. All the maps are already here in the book. Gary Critzer said, so to revisit the motion, should we start with where we are today? Dr. Jack Potter said no, he's saying that if we were to build this from the ground up, how would we define the variables, how would we decide the factors that would drive these decisions and how would we rank them? Gary Critzer said that basically we are to act as if there are no regional councils today. Dr. Potter replied, yes theoretically. Gary Brown stated that we have a list of objectives that were used before. Dr. Kaplowitz thinks it is unrealistic to start from scratch because the people are starting from where they are now. What Map C does is actually merge the smaller councils. **Back to the motion: Gary Critzer stated that the motion on the floor is to utilize the criterion that has been developed to evaluate the service area maps and rank them according to importance.**	

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	Gary Brown said that the committee has already identified those criteria and variables in the Charter of the PAT and I think this needs to drive what we are doing and why we are here. **Motion approved to evaluate and rank the objectives listed under the PAT Charter - Scope of Service.** It was agreed to rank the objectives on a scale of 1 to 5 with 1 being the most important and 5 being the least important. Objective #1 – Effective coordination of regional flow of patients. To implement a regional EMS system that is a natural catchment area for EMS provision for most, it not all, patients in the designated area. Arrangement must allow community hospitals, trauma centers, and pre-hospital EMS to work effectively together. **Rank 1** Objective #2 – Promote the integration of community and public health systems and resources, and disaster response training and readiness of EMS personnel for terrorist attacks, natural disasters, or other public health emergencies. **Rank 4** Objective #3 – Organize regional service areas to establish a "critical mass" capable of conducting system performance improvement using boundaries that better resemble specialty regions for trauma, stroke, etc. The recent ASMI study on the Regional EMS Councils in Virginia stated, "The resulting regions would be larger, have deeper staff resources, affect some economies of scale, be able to offer varying services to urban and rural providers, and begin to implement system performance improvement on a scale and with boundaries better resembling specialty care regions." **Rank 2** Objective #4 – Improved efficiencies in coordination, planning, preparedness, and administration of services on a regional level. Proposed regional service area must be fully integrated with local health districts, hospital planning and preparedness regions, and health system agency service areas. **Rank 1** Objective #5 – Identify the most effective geographic deployment of resources. The proposed regional service areas shall take into consideration the areas of demographic concentration, as well as some of the natural geographic boundaries (mountains, rivers, etc.) that exist in Virginia. **Rank 1** Objective #6 – Promote the goal of a more integrated, coordinated, and accountable regionalized emergency medical care system. **Not ranked. This is not a discerning factor. This should occur regardless.** Objective #7 – Promote the development of "regional accountable systems" while minimizing their differences and eliminating fragmentation of services. **Not ranked. This is not a discerning factor. This should occur regardless.** Objective #8 – Consider the location of existing licensed EMS agencies and vehicles, future growth and	

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	expansion of these service, and create opportunities to enhance the facilitation, coordination and integration of emergency medical services on a regional level. **The committee decided to separate the statement into two parts; separating at "future growth". Both parts Rank 3.** Objective #9 – Raise the overall level of service and decrease the variations that exist, and promote an enhanced, comprehensive delivery of services to a larger number of EMS system stakeholders. **Rank 2** Gary Critzer wanted to know, now that we have prioritized the objectives, how do apply that to service area boundaries and where do we start? **It was decided to start with Map C.** Jason suggested that the Regional Council Directors from those areas give reasons why the objectives don't fit their particular regions. Per Gary Critzer the committee will look the top three priorities which are objectives 1, 4 and 5. The committee began by looking at Region A which is currently the Southwest Region. Greg Woods of the Southwest Virginia EMS Council reported that there are no Trauma Centers in the region. The closest Trauma Centers are in Kingsport and Bristol, Tennessee. Most trauma patients are transported to local hospitals. There are hospitals in Galax, Smyth County, Tazewell, Washington and other counties. Per Tim, the Southwest Regional Council gets the largest amount of their funding from the Office of EMS than any other source. As of the 2006 audit, they get 79% from OEMS. Next the committee looked at Region B which consists of combining the Blue Ridge and Western Virginia EMS Regions. Connie Purvis, of the BREMS Region, is a part of that proposed area. She stated that she does not believe in boundaries of the regional councils. BREMS has services that go into WVEMS and they have services that come into BREMS. We have worked very hard with the Western area in standardizing our drug boxes for better patient care. Per Tim, the BREMS region gets 54% of their funding from OEMS. The BREMS region is extremely well managed and has no financial issues. We are not opposed to change, but the elimination of an office in Lynchburg is not something that we would welcome. Connie Purvis and Rob Logan both agree that their working relationships would not change if they integrated. Connie would like to have no change at all, but if they absolutely had to change, they would support it. Her main concern is the geographic flow of the system and how that would impact services. Per Tim, the Western Region is the lowest funded region by OEMS. Region C consists of combining the Central Shenandoah and Lord Fairfax Regions. Tracey McLaurin of the LFEMS Region stated that historically their council had issues because the director was sick with cancer and had planned to return, but that did not occur. So we are in the process of improving our system. If you look at the current patient flow, we get a lot of patients from West Virginia, being that Winchester Medical Center is a Level II trauma center. We are working with our hospital preparedness group to improve the services in our area. There was some discussion about mountains being to the east and west of the regional council area. According to the 2006 Lord Fairfax audit, they get 67% of their funding from OEMS and Central Shenandoah reported 90%.	

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	Region D is the Old Dominion EMS Alliance. Tracy Thomas of the ODEMSA Region reported that they are in favor of Map C because of the relationships that they have already formed. She has been the executive director for only 21 days. There have been challenges in the past due to the changes in executive directors, but we are working through those. The question in my mind is whether changing the boundaries are going to change the struggles. Seems as though the problems are due to a lack of responsibility or a lack of collaboration. Hopefully there are some significant financial savings in merging the regions. It would be a good idea to get the executive directors together to evaluate and discuss what we are doing, why and how we are doing it and if there is a more efficient way of delivering the same or better services. It strikes me as odd but that seems to be what this meeting is all about. My group opposes change just for the sake of boundary change. My constituents told me that they look forward to working with me and want to know what I can do to assist the Commonwealth in this transition if there is one. The ODEMSA region has sub regions, Gary Critzer asked what kind of feeling she has about the strengths and weaknesses of each sub region. Tracy stated that she has attended three of the four sub council meetings. In each of the meetings, they discussed a couple of things that they have found that works really well and not surprisingly, they have been able to draw from the strengths of the paid professional services in our service area. If we have challenges, they seem to be more of personality conflicts. Per Tim, ODEMSA receives 37% of its funding from OEMS. Chris Eudaily suggested that the next PAT meeting be in the Fredericksburg area. Per Gary, that is acceptable because they were planning to go South or North.	
Next Steps:	Regions E, F and H to be discussed at the next meeting.	
Next Meeting Date:	Tuesday, June 3 in the Fredericksburg area at approximately 8:30 to 3:30. Place to be determined.	
Public Comment Period:	No comments were made.	
Adjournment	The meeting was adjourned at 3:05 p.m.	